MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

REC'D SEP 9 1941

27946
Do not use this space.

1. PLACE OF DEATH
(a) County Cape Girardeau — Registration District No. 121
(b) Township ,, — Primary Registration District No. 3009 — Registered No. 2991
or
(c) City ,, — (d) Street No. ST. FRANCES HOSPITAL St.
(If death occurred in Hospital or Institution, write its name instead of street and number)
(e) Length of residence in city or town where death occurred 14 yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

2. PRINT FULL NAME LETTIE BRYAN
(a) Residence, No. 314 N. MIDDLE St.
(Usual place of abode, if no street address, write county or city) (If nonresident, give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
FEMALE	WHITE	SINGLE

5A. IF MARRIED, WIDOWED, OR DIVORCED
HUSBAND OF
(OR) WIFE OF

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) DEC. 24 1908

7. AGE	YEARS	MONTHS	DAYS	If LESS than 1 day, ...hrs. or ....min.
	32	7	13	

OCCUPATION
8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. HOUSEWORK
9. Industry or business in which work was done, as saw mill, bank, etc.
10. Date deceased last worked at this occupation (month and year) 7-5-41
11. Total time (years) spent in this occupation 14 YRS.

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) COOTER Missouri

FATHER
13. NAME ISAC BRYAN
14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) GEORGIA

MOTHER
15. MAIDEN NAME NEFF
16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) JACKSON TENNESSEE

17. INFORMANT MRS. JAMES A. WALLER
(ADDRESS) 314 N. MIDDLE

18. BURIAL, CREMATION, OR REMOVAL
PLACE MEMORIAL PARK DATE 8-7 1941

19. FUNERAL DIRECTOR (NAME) WALTHER'S
(ADDRESS) 260 N. MIDDLE

20. FILED 8-6 1941 J. M. Thompson
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 8-6 1941

22. I HEREBY CERTIFY, That I attended deceased from 7-3 1941, to 8-6 1941
I last saw h..... alive on ....., 19..... Death is said
to have occurred on the date stated above, at .....m.
The principal cause of death and related causes of importance were as follows:

	Date of onset
PERITONITIS BC	
	7-29
Other contributory causes of importance: CARCINOMA	

Name of operation ABDOMINAL Date of 8/1/41
What test confirmed diagnosis? ..... Was there an autopsy? NO

23. If death was due to external causes (violence), fill in also the following:
Accident, suicide, or homicide? ..... Date of injury ....., 19.....
Where did injury occur? .....
(Specify city or town, county, and State)
Specify whether injury occurred in industry, in home, or in public place.
Manner of injury .....
Nature of injury .....

24. Was disease or injury in any way related to occupation of deceased? .....
If so, specify .....
(Signed) O. K. Bell M. D.
(Address) Cape Girardeau Mo

(Licensed Embalmer's Statement on Reverse Side)

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed J. H. Foster

Licensed Embalmer No. 3980

P. O. Address Cape Girardeau

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to compl with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.

S. No. 2B
1—8-21-41
I X29288

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 27946

Registration District No. 125 Primary Registration District No. 2993009 Registrar's No. 299

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Cape Girardeau
(b) City or town ..... (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: ..... (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ..... (Specify whether years, months or days)
In this community .....

2. USUAL RESIDENCE OF DECEASED:
(a) State Mo. (b) County Cape Girardeau
(c) City or town Cape Girardeau (If outside city or town limits, write "RURAL")
(d) Street No. 314 N. Middle (If rural, give location)
(e) Citizen of foreign country? ..... (Yes or No)
If yes, name country .....

3. (a) PRINT FULL NAME Lettie Bryan
3. (b) If veteran, name war .....
3. (c) Social Security No. .....

4. Sex F | 5. Color or race W | 6. (a) Single, widowed, married, divorced W

6. (b) Name of husband or wife .....
6. (c) Age of husband or wife if alive ..... years

7. Birth date of deceased ..... (Month) (Day) (Year)

8. AGE: Years | Months | Days | If less than one day ..... hr. ..... min.

9. Birthplace ..... (City, town, or county) (State or foreign country)

10. Usual occupation .....

11. Industry or business .....

MOTHER FATHER
12. Name .....
13. Birthplace ..... (City, town, or county) (State or foreign country)
14. Maiden name .....
15. Birthplace ..... (City, town, or county) (State or foreign country)

16. (a) Informant .....
(b) Address .....

17. (a) ..... (Burial, cremation, or removal) (b) Date thereof ..... (Month) (Day) (Year)
(c) Place: burial or cremation .....

18. (a) Signature of funeral director .....
(b) Address .....

19. (a) ..... (Date received local registrar) (b) ..... (Registrar's signature)

SUPPLEMENTARY

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day ..... year 1941 hour ..... minute ..... M.

21. I hereby certify that I attended the deceased from ..... 19..... to ..... 19.....; that I last saw h... alive on ..... 19.....; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations .....
Of autopsy .....

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) .....
(b) Date of occurrence .....
(c) Where did injury occur? ..... (City or town) (County) (State)
(b) Did injury occur in or about home, on farm, in industrial place, in public place? ..... (Specify type of place)
While at work? ..... (e) Means of injury .....

23. Signature ..... (M. D. or other)
Address ..... Date signed .....